		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0000091

Facility Name: Hancock County Nursing Home

Address: P.O. Box 160, South Adams Street (Number) | Carthage (City) | 62321 (Zip Code)

County: Hancock

Telephone Number: (217) 357-3131 **Fax #** (217) 357-6076

IDPA ID Number: 6004022

Date of Initial License for Current Owners: 05/23/1905

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jan Fleming **Telephone Number:** (217) 357-3131 ext. 2209

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/03 to 6/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) BKD, LLP, 501 N. Broadway, Suite 600
(Telephone) (314) 231-5544 Fax # (314) 231-9731

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	57	Intermediate (ICF)	57	20,862	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	8,947	9,167	266	18,380	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,947	9,167	266	18,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.10%

D. How many bed-hold days during this year were paid by Public Aid?
99 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: N/A Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Hancock County Nursing Home # 0000091 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary			4,184	4,184		4,184		4,184			1
2	Food Purchase		235,200		235,200		235,200		235,200			2
3	Housekeeping	53,107	586		53,693		53,693		53,693			3
4	Laundry	4,918		35,330	40,248		40,248		40,248			4
5	Heat and Other Utilities			77,756	77,756		77,756	(32,012)	45,744			5
6	Maintenance	41,960	3,396	21,060	66,416		66,416	(27,343)	39,073			6
7	Other (specify):*	2,622			2,622		2,622		2,622			7
8	**TOTAL General Services**	102,607	239,182	138,330	480,119		480,119	(59,355)	420,764			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	799,345	45,407	5,593	850,345		850,345		850,345			10
10a	Therapy			4,358	4,358		4,358		4,358			10a
11	Activities	36,995	6,384	141	43,520		43,520		43,520			11
12	Social Services	12,868	300	250	13,418		13,418		13,418			12
13	Nurse Aide Training											13
14	Program Transportation			1,511	1,511		1,511		1,511			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	849,208	52,091	16,653	917,952		917,952		917,952			16
	C. General Administration											
17	Administrative		392	10,777	11,169		11,169		11,169			17
18	Directors Fees											18
19	Professional Services			161	161		161		161			19
20	Dues, Fees, Subscriptions & Promotions			7,959	7,959		7,959	(3,402)	4,557			20
21	Clerical & General Office Expenses	29,440	1,651	8,740	39,831		39,831		39,831			21
22	Employee Benefits & Payroll Taxes			334,269	334,269		334,269		334,269			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,830	3,830		3,830		3,830			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			25,550	25,550		25,550	(8,666)	16,884			26
27	Other (specify):*											27
28	**TOTAL General Administration**	29,440	2,043	391,286	422,769		422,769	(12,068)	410,701			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	981,255	293,316	546,269	1,820,840		1,820,840	(71,423)	1,749,417			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hancock County Nursing Home #0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			104,303	104,303		104,303	(34,074)	70,229			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			130	130		130		130			35
36	Other (specify):*											36
37	**TOTAL Ownership**			104,433	104,433		104,433	(34,074)	70,359			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	8,947	759	1,447	11,153		11,153		11,153			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,293	31,293		31,293		31,293			42
43	Other (specify):* **Nauvoo Housing**		671	12,961	13,632		13,632	(13,632)				43
44	**TOTAL Special Cost Centers**	8,947	1,430	45,701	56,078		56,078	(13,632)	42,446			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	990,202	294,746	696,403	1,981,351		1,981,351	(119,129)	1,862,222			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(68,021)	5,6,26		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(34,074)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,402)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(13,632)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (119,129)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (119,129)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Hancock County Nursing Home

ID# 0000091

Report Period Beginning: 7/1/03

Ending: 6/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Rented facility space utilities	$ (32,012)	5	1
2	Rented facility space maintenance	(27,343)	6	2
3	Rented facility space property insurance	(8,666)	26	3
4	Nauvoo Housing - Carrie Manor	(13,632)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(81,653)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(32,012)	0	0	0	0	0	0	0	0	0	0	(32,012)	5
6	Maintenance	(27,343)	0	0	0	0	0	0	0	0	0	0	(27,343)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(59,355)	0	0	0	0	0	0	0	0	0	0	(59,355)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,402)	0	0	0	0	0	0	0	0	0	0	(3,402)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(8,666)	0	0	0	0	0	0	0	0	0	0	(8,666)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(12,068)	0	0	0	0	0	0	0	0	0	0	(12,068)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,423)	0	0	0	0	0	0	0	0	0	0	(71,423)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hancock County Nursing Home # 0000091 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(34,074)	0	0	0	0	0	0	0	0	0	0	(34,074)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(34,074)	0	0	0	0	0	0	0	0	0	0	(34,074)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,632)	0	0	0	0	0	0	0	0	0	0	(13,632)	43
44	**TOTAL Special Cost Centers**	(13,632)	0	0	0	0	0	0	0	0	0	0	(13,632)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(119,129)	0	0	0	0	0	0	0	0	0	0	(119,129)	45

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	NONE	8
2000	NONE	9
2001	NONE	10
2002	NONE	11
2003	NONE	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hancock County Nursing Home COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0000091

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,877 B. General Construction Type: Exterior Block Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1989	$ 23,718	1
2					2
3	TOTALS			$ 23,718	3

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	52		1970	1970	$ 848,870	$ 5,883	10 to 40	$ 5,883	$	$ 810,748	4
5	5		1992	1992	1,243,226	35,788	5 to 40	35,788		492,305	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements:										9
10	Storm Windows			1983	16,349	585	28	585		12,556	10
11	Handrails, reconditioned motor, ignition, switch, & control switch			1993	4,645	248	10 to 15	248		3,781	11
12	Deaerator			1990	13,726	918	15	918		13,271	12
13	Air conditioner compressor			1994	6,371	451	15	451		4,272	13
14	Drapes and door for storage room			1996	2,534	48	5 to 15	48		2,051	14
15	Generator work			1996	3,570	179	20	179		1,338	15
16	Stairway carpet			1997	1,022		5			1,022	16
17	Generator work			1997	1,198	60	20	60		449	17
18	Roof repair			1997	1,084	109	10	109		813	18
19	Roof repair			1997	16,200	1,624	10	1,624		12,148	19
20	Roof replacement			1998	36,200	3,630	10	3,630		23,525	20
21	Cooling unit			1998	1,634	164	10	164		1,062	21
22											22
23	Wall paper and paint			1999	11,623	2,331	5	2,331		10,458	23
24	Carpeting & tile			1999	26,198	2,637	5 to 10	2,637		22,572	24
25	Compressor			1999	4,893	327	15	327		1,467	25
26	Door locks			2000	510	34	15	34		153	26
27	Cooling tower			2000	7,041	353	20	353		1,584	27
28	Burner for boiler			2003	43,350	2,173	20	2,173		3,248	28
29	Red Oak Doors			2004	6,075	202	15	202		202	29
30	Generator work			2004	23,369	777	15	777		777	30
31											31
32											32
33											33
34											34
35	Less 41.17% allocation to rental space				(955,016)	(24,093)		(24,093)		(584,532)	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements Continued:		$	$		$	$	$	37
38	Fully Depreciated Improvements by calendar year:								38
39	1984	1984	1,132					1,132	39
40	1987	1987	9,160					9,160	40
41	1988	1988	2,045					2,045	41
42	1989	1989	3,226					3,226	42
43	1990	1990	194					194	43
44	1993	1993	7,770					7,770	44
45	1994	1994	1,964					1,964	45
46	1995	1995	3,277					3,277	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Less 41.17% allocation to rental space		(11,844)					(11,844)	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,381,596	$ 34,428		$ 34,428	$	$ 852,194	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,381,596	$ 34,428		$ 34,428	$	$ 852,194	1
2									2
3	Land Improvements:								3
4									4
5	1989 Improvements	1989	615	7	12 to 15	7		615	5
6	1992 Improvements	1992	7,007	468	15	468		5,840	6
7	Landscaping gazebo area	1994	343	17	10	17		343	7
8	Asphalt parking lot	1996	33,506	4,200	8	4,200		31,406	8
9	Fence	1998	9,303	622	15	622		4,031	9
10	Asphalt sealer	1998	4,390		8			4,390	10
11	Asphalt parking lot sealer	2002	2,111	532	8	532		2,111	11
12	DRIVEWAY SEALER	2004	4,017	250	8	250		250	12
13									13
14	Fully depreciated improvements by calendar year:								14
15	1973	1973	7,768					7,768	15
16	1987	1987	2,395					2,395	16
17	1989	1989	765					765	17
18	1992	1992	375					375	18
19	1993	1993	2,258					2,258	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,456,449	$ 40,524		$ 40,524	$	$ 914,741	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 269,791	$ 16,485	$ 16,485	$	3 to 15	$ 193,492	71
72	Current Year Purchases	16,624	1,120	1,120		5 to 12	1,120	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 286,415	$ 17,605	$ 17,605	$		$ 194,612	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1991 Ford van	1992	$ 17,463	$	$	$	4	$ 17,463	76
77	Patient Transportation	Lift	1989	2,575				10	2,575	77
78	Patient Transportation	2001 Ford E/350 van	2001	47,953	12,021	12,021		4	41,942	78
79										79
80	TOTALS			$ 67,991	$ 12,021	$ 12,021	$		$ 61,980	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,834,573	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 70,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 70,150	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,171,333	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Allocation to rental space	$ 966,860	$ 24,093	$ 596,376	86
87	Grey House-Education Building	61,015	3,170	53,668	87
88	Nauvoo Housing-Carrie Manor	290,683	6,777	107,942	88
89	Beauty Shop	922	34	529	89
90					90
91	TOTALS	$ 1,319,480	$ 34,074	$ 758,515	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Hancock County Nursing Home # 0000091 **Report Period Beginning:** 7/1/03 **Ending:** 6/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 912,582	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,000)	115,956		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,430		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	382,054		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,412,022	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,741		13
14	Buildings, at Historical Cost	2,045,984		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	992,273		16
17	Accumulated Depreciation (book methods)	(1,930,202)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,524,449		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,749,245	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,161,267	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,184	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,261		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Other Accrued Expenses	5,907		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 108,352	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	1,900		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,900	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 110,252	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,051,015	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,161,267	$	48

***(See instructions.)**

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,962,841	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,962,841	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(53,677)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	141,851	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 88,174	17
	B. Transfers (Itemize):		
18	**Contributions to Restricted Net Assets**		18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,051,015	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,117,381	1
2	Discounts and Allowances for all Levels	(366,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,751,381	3
	B. Ancillary Revenue		
4	Day Care	3,878	4
5	Other Care for Outpatients		5
6	Therapy	4,833	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,711	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,580	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	45,600	16
17	Sale of Drugs	67	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	10,490	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,737	23
	D. Non-Operating Revenue		
24	Contributions	9,890	24
25	Interest and Other Investment Income***	75,254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 85,144	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nauvoo Housing Rents	21,829	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,829	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,927,802	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	480,119	31
32	Health Care	917,952	32
33	General Administration	422,769	33
	B. Capital Expense		
34	Ownership	104,433	34
	C. Ancillary Expense		
35	Special Cost Centers	56,078	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Miscellaneous Expense	128	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,981,479	40
41	**Income before Income Taxes (line 30 minus line 40)****	(53,677)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (53,677)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,088	$ 67,428	$ 32.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,838	6,093	155,931	25.59	3
4	Licensed Practical Nurses	9,383	9,663	153,648	15.90	4
5	Nurse Aides & Orderlies	43,473	44,840	418,075	9.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,164	2,230	23,140	10.38	9
10	Activity Assistants	1,567	1,615	13,855	8.58	10
11	Social Service Workers	773	797	12,868	16.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,245	3,346	41,960	12.54	17
18	Housekeepers	7,455	7,686	53,107	6.91	18
19	Laundry	786	810	4,918	6.07	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	507	523	11,081	21.19	22
23	Office Manager					23
24	Clerical	1,015	1,046	18,359	17.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	305	314	4,262	13.57	31
32	Other Health Care(specify)	127	131	2,623	20.02	32
33	Other(specify) Barber & Beauty	858	890	8,947	10.05	33
34	TOTAL (lines 1 - 33)	79,584	82,072	$ 990,202 *	$ 12.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	102	$ 4,184	Ln 1, Col 3	35
36	Medical Director	24	4,800	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	60	2,986	Ln 10a, Col 3	40
41	Occupational Therapy Consultant	29	1,372	Ln 10a, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	10	575	Ln 10, Col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	225	$ 13,917		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Pinkerton Services - compliance reporting line	$ 617
Investment Fees	10,160
TOTAL (agree to Schedule V, line 17, col. 3)	$ 10,777
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hartzell, Glidden, Tucker, Hartzell	Legal Fees	$ 161
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 161

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,901
Unemployment Compensation Insurance	
FICA Taxes	59,885
Employee Health Insurance	245,707
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other	2,197
Life Insurance	1,017
Retirement Contribution	8,841
Dental Insurance	6,721
TOTAL (agree to Schedule V, line 22, col.8)	$ 334,269

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 5)	60
Activity Fees	15
Administrative Subscriptions	266
NH Association dues	4,216
Plublic Relations Advertising	3,402
Less: Public Relations Expense	( )
Non-allowable advertising	(3,402)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,557

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,830
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,830

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hancock County Nursing Home # 0000091 Report Period Beginning: 7/1/03 Ending: 6/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $2,491, INHAA - $100, IDPA - $1,500**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,992** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **31,293**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **99**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not yet Completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME: Hancock County Nursing Home
ID#: 0000091

BEGINNING: 7/1/03
ENDING: 6/30/04

BOARD OF DIRECTORS

Larry McClintock, Secretary/Treasurer
Dan Asbury
Kathy Holst
Sharon Morrison
Kris Dornbush

Don Griffiths, Jr., Vice President
Matt Dickinson
Dr. Edward McKenney
Janet Grimm
LuAnn Haas, President
John Faulhaber

Board members are not compensated. None of the Board members provided services to or conducted business transactions with the nursing home, either directly or indirectly.

FACILITY NAME: Hancock County Nursing Home
ID#: 0000091

BEGINNING: 7/1/03
ENDING: 6/30/04

VI. ADJUSTMENT DETAIL **RENTED FACILITY SPACE**

Non-care space rented to Memorial Hospital.

Occupancy costs allocated based on square footage.

Department Use	Square Feet Gross	Nursing Home %	Hospital (Non-Care) %	Nursing Home Sq. Ft.	Hospital (Non-Care) Sq. Ft.
Upper Level - Nursing Home	15,585	100.0%	0.00%	15,585	-
Lower Level - Shared Space:					
Allocated by time spent:					
Medical Records	1,418	5.00%	95.00%	71	1,347
Business Office	264	1.00%	99.00%	3	261
Data Processing	416	3.00%	97.00%	12	404
Pharmacy	912	0.00%	100.00%	-	912
Physical Therapy	160	0.00%	100.00%	-	160
Occupational Therapy	160	0.00%	100.00%	-	160
Nursing Admin Office	253	0.00%	100.00%	-	253
CFO	206	7.00%	93.00%	14	192
Purchasing	192	5.00%	95.00%	10	182
Accounting	216	5.50%	94.50%	12	204
Personnel	121	7.00%	93.00%	8	113
Administration	281	30.00%	70.00%	84	197
Risk Management	214	5.00%	95.00%	11	203
Beauty Shop	192	100.00%	0.00%	192	-
Subtotal	5,005	8.33%	91.67%	417	4,588
Common areas	7,700	8.33%	91.67%	641	7,059
Subtotal	12,705		-	1,058	11,647
Allocated by square feet:					
Plant operations	2,665	58.83%	41.17%	1,568	1,097
Housekeeping	160	58.83%	41.17%	94	66
Total lower level	15,530		-	2,720	12,810
Total facility space	**31,115**			**18,305**	**12,810**
					-
Net rented space	**12,810**	**41.17%**			
Total facility space	**31,115**	**100.00%**			

Occupancy Costs	Total Costs	Allocation %	Non-Care Allocation	Sch V Line Ref
Utilities	$77,756	41.17%	$32,012	5
Maintenance	66,416	41.17%	27,343	6
Property Insurance	21,050	41.17%	8,666	26
Totals	$165,222		$68,021	